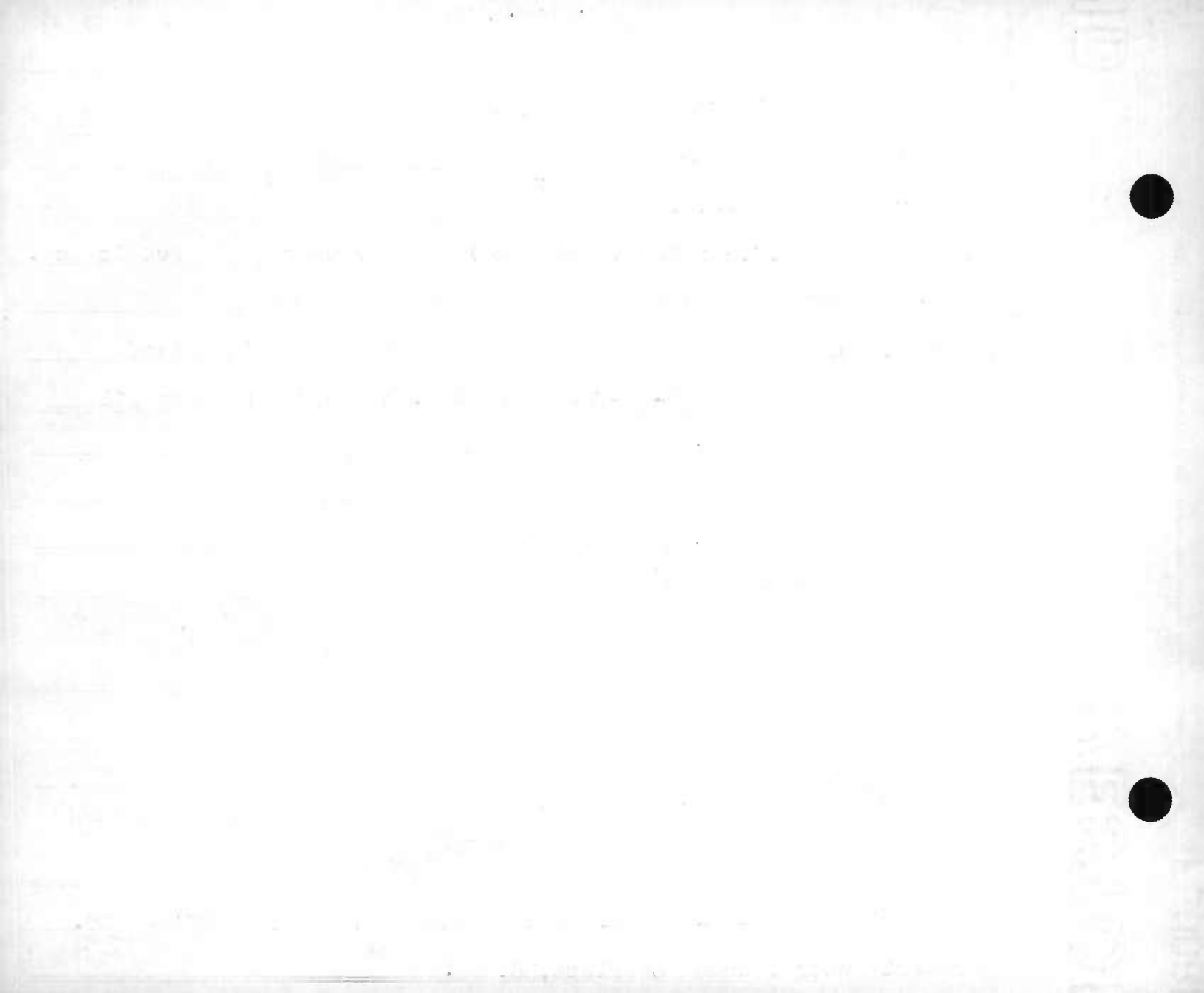


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner (must be notified) please.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 1 2 6 6 5 8
1. FOR STATE REGISTRAR										REG. NO.
1. DECEASED NAME (TYPE OR PRINT) Phyllis BUCKLEY BARBOUR					2a. DATE OF DEATH MONTH DAY YEAR 10 9 81			2b. HOUR 12:15PM		
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 7 11 18		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles County MD				
10. CITY OR TOWN OF DEATH Port Tobacco		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) P.O. Box 386 (Residence)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY Public Sch.		
13a. STATE MD				13b. CITY OR TOWN Charles Port Tobacco		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS P.O. Box 386		
14. FATHER'S NAME FIRST MIDDLE LAST Henry F. Buckley				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosemary Conay Switzerland						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO 217-42-2969		17. INFORMANT ADDRESS Robert T. Barbour same as #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Thrombosis post Coronary artery</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>Carcinoma of the left Breast</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>[Signature]</u> MD DEGREE						22c. DATE SIGNED 10/10/81		22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		
22e. PHYSICIAN'S NAME (TYPE OR PRINT) M-S. COCURN						22f. ADDRESS PMH.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10-13-81		23c. NAME OF CEMETERY OR CREMATORY Mt. Rest Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE La Plata Charles Md.			
24. FUNERAL DIRECTOR NAME Arehart Funeral Home						25. DATE RECEIVED BY REGISTRAR OCT 16 1981				
26. FUNERAL DIRECTOR ADDRESS La Plata, Md.						27. REGISTRAR'S SIGNATURE <u>[Signature]</u>				



SSN: 232-18-8999

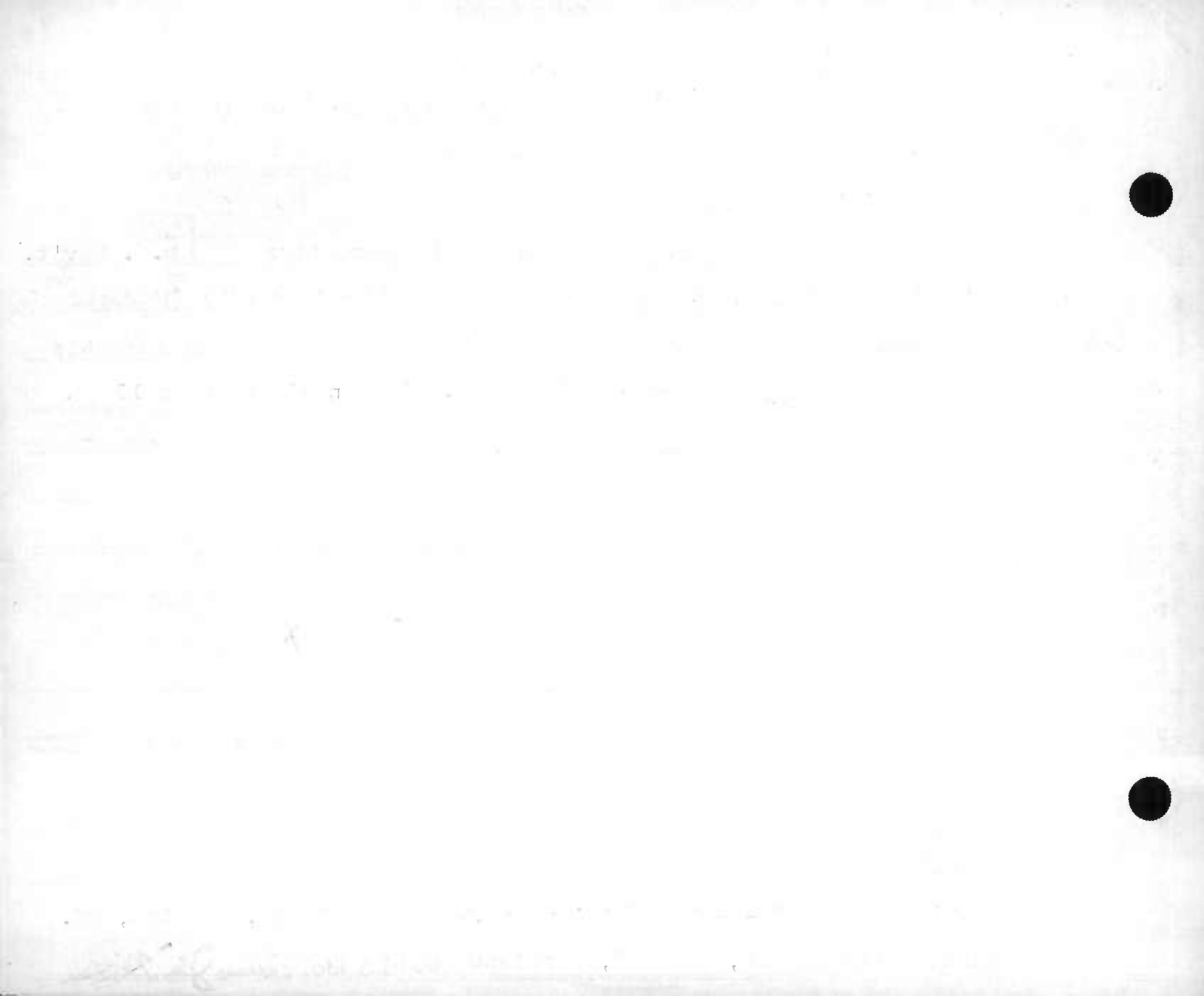
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1	2 6 6 5 9
1. FOR STATE REGISTRAR				REG. NO.	
2. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH MONTH DAY YEAR	
Clarence Arvel Blankenship				October 6 1981 1 41 A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR	
Male		Cau.		02-06-16	
6. AGE (IN YEARS LAST BIRTHDAY)		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	
65 YRS.		West Virginia		USA	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
		Charles MD			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
LA PLATA		Physicians Memorial		Carpenter	
12b. KIND OF BUSINESS OR INDUSTRY		12c. STREET ADDRESS			
U.S. Gov't.		RFD 1 Box 112 Bryans Rd. 206/6017			
13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13b. STREET ADDRESS			
		RFD 1 Box 112 Bryans Rd.			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
Henry Blankenship		Bessie Blankenship			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes		232-18-8999		Ruth I. Blankenship same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1629 Cardiac arrest					
DUE TO, OR AS A CONSEQUENCE OF (b) Respiratory Collapse 3 days					
DUE TO, OR AS A CONSEQUENCE OF (c) Squamous Cell Carcinoma, Lung 3 months					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 14 Sept 1981 to 6 Oct 1981, that (I) (we) last saw the deceased alive on 5 Oct 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		22c. DEGREE		22d. DATE SIGNED	
ARTHUR O. Woody MD		MD		6 Oct 81	
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22f. ADDRESS			
ARTHUR O. Woody MD PA		Box 430 LA PLATA, MD 20646			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		10-8-81		Trinity Mem. Gardens	
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR			
Charles, Md.		OCT 13 1981			
24. FUNERAL DIRECTOR NAME ADDRESS		25a. REGISTRAR'S SIGNATURE			
Hunt Funeral Home, Waldorf, Maryland		James J. Watkins			



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Ruby Smith Boswell</b>			2a. DATE OF DEATH MONTH <b>10</b> DAY <b>29</b> YEAR <b>81</b>			2b. HOUR <b>12:30 AM</b>				
3 SEX <b>Female</b>		4 RACE <b>Cau.</b>		5 DATE OF BIRTH MONTH <b>July</b> DAY <b>29</b> YEAR <b>1892</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>89</b> YRS		7 IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b> IF UNDER 74 HRS. HOURS <b></b> MIN. <b></b>		
8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Charles</b> MD.				
10 CITY OR TOWN OF DEATH <b>La Plata</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Charles County Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Self Employed</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Charles</b>		13c. CITY OR TOWN <b>La Plata</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>P.O. Box 453</b>	
14. FATHER'S NAME FIRST <b>Henry</b> MIDDLE <b>M.</b> LAST <b>Smith</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Alberta</b> MIDDLE <b>C.</b> LAST <b>Peck</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO <b>217-32-1499</b>		17. INFORMANT ADDRESS <b>Joseph F. Boswell same as 13</b>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>pulmonary edema</b> <b>4140</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>cardiopulmonary arrest</b> (c) <b>arteriosclerosis heart disease</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b> <b>15 yr</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>dehydration, electrolyte imbalance, anorexia</b>										
19a. DATE OF OPERATION <b>none</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>n/a</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSE OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>n/a</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>n/a</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>n/a</b>		21f. LOCATION STREET <b>n/a</b> CITY OR TOWN <b>n/a</b> COUNTY <b>n/a</b> STATE <b>n/a</b>					
22a. I certify that (I) (this hospital) attended the deceased from <b>10/29/81</b> to <b>10/29/81</b> , that (I) (we) last saw the deceased alive on <b>10/29/81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Paul E. Pritchett M.D.</b>			DEGREE <b>M.D.</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>10/29/81</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Paul E. Pritchett, M.D.</b>			22e. ADDRESS <b>La Plata, Maryland 20646</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>11-2-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat. Cem.</b>		23d. LOCATION CITY OR TOWN <b>Arlington</b> COUNTY <b>Virginia</b> STATE <b></b>			
24. FUNERAL DIRECTOR NAME <b>Hunt Funeral Home</b> ADDRESS <b>Stallord, Md.</b>			25a. DATE REC'D. BY REGISTRAR <b>NOV 02 1981</b>			25b. REGISTRAR'S SIGNATURE <b>Charles J. Nathan</b>				

83  
90  
35  
80  
1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. For retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

ME

Female  
Jan.  
July 28, 1932  
Charles  
Maryland  
Charles  
Harry  
M. Smith  
Albany  
C. 1934  
11-7-31-1932  
Joseph E. Smith (son of J.)

*[Faint, mostly illegible handwritten notes and signatures]*

Paul E. Patterson, W.D.  
Le Pigeon, Island 2848  
11-7-31  
Virginia  
11-7-31  
11-7-31

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 2 6 0 6 1

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Angela Frances CARROLL</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>October 07 '81</b>		2b. HOUR 9:03 <b>A</b> M.	
3. SEX <b>Female</b>		4. RACE <b>Cau.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 10 1910</b>	
6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>Charles</b> MD.					
10. CITY OR TOWN OF DEATH <b>La Plata</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Physicians Memorial</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>					
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Charles</b>		13c. CITY OR TOWN <b>La Plata</b>	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>Box 220, La Plata, 20646</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Lawrence P. Dorr</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Catherine Perry</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>577-07-0663</b>		17. INFORMANT ADDRESS <b>Thomas W. Carroll same as #13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>5325</b> IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Sepsis shock</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Perforated duodenal ulcer</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 m</b> <b>3 days.</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>Severe arthritis on rheumatoid for 12 years.</b>					
19a. DATE OF OPERATION <b>04 Oct 81</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Repair of perforated</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>4 January 19 81</b> to <b>7 Oct 19 81</b> , that (I) (we) saw the deceased alive on <b>6 Oct 19 81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Arthur C. Woody, MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>7 Oct 81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ARTHUR C. WOODY, MD</b>		22e. ADDRESS <b>Box 430 La Plata, MD. 20646</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10-9-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Md. Veterans Cem.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cheltenham P.G. Maryland</b>					
24. FUNERAL DIRECTOR NAME <b>Arehart Funeral Home</b>		ADDRESS <b>La Plata, Md.</b>		25a. RECORDED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>OCT 13 1981</b> <b>Frances Jan. Withers</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and it must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE  
WASHINGTON, D. C. 20535



100-33-1000

Investigation

Report

100-33-1000

23

100-33-1000

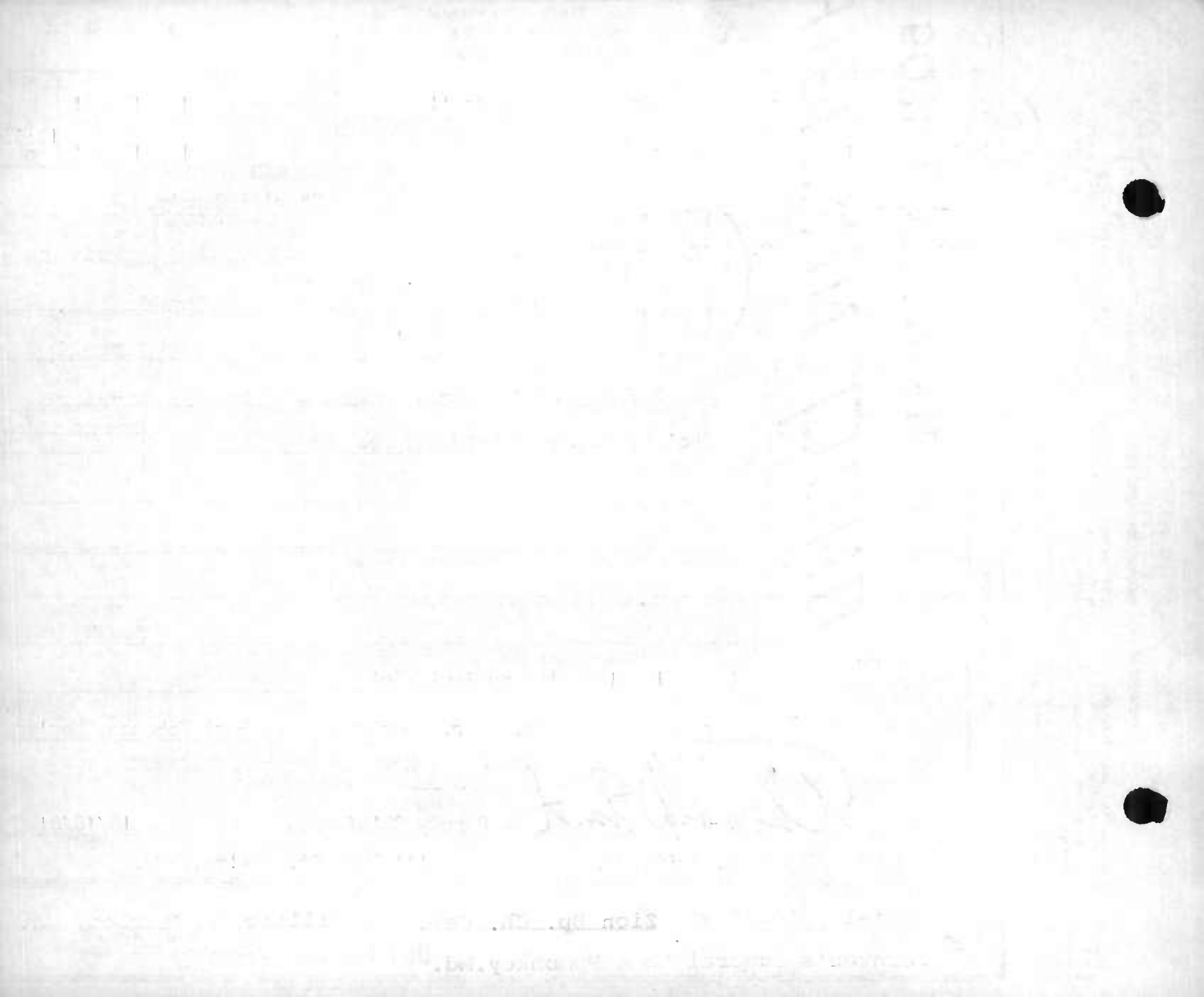
100-33-1000



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 26062	
1. FOR STATE REGISTRAR										2a. DATE OF DEATH	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Gregory Andre Carroll										2b. HOUR 10:15	
2. SEX Male										2c. DATE OF DEATH	
3. RACE Black										2d. DATE OF DEATH	
4. DATE OF BIRTH MONTH DAY YEAR 7 18 59										2e. DATE OF DEATH	
5. AGE (IN YEARS LAST BIRTHDAY) 22 YRS.										2f. DATE OF DEATH	
6. IF UNDER 1 YR. MONTHS DAYS										2g. DATE OF DEATH	
7. IF UNDER 24 HRS. HOURS MIN.										2h. DATE OF DEATH	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland										2i. DATE OF DEATH	
7b. CITIZEN OF WHAT COUNTRY? USA										2j. DATE OF DEATH	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										2k. DATE OF DEATH	
9. BALTIMORE CITY OR COUNTY OF DEATH Charles County, MD.										2l. DATE OF DEATH	
10. CITY OR TOWN OF DEATH Port Tobacco										2m. DATE OF DEATH	
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 6 nr. Poorhouse Rd.										2n. DATE OF DEATH	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Janitorial										2o. DATE OF DEATH	
12b. KIND OF BUSINESS OR INDUSTRY Private										2p. DATE OF DEATH	
13a. STATE Maryland										2q. DATE OF DEATH	
13b. COUNTY Charles										2r. DATE OF DEATH	
13c. CITY OR TOWN Port Tobacco										2s. DATE OF DEATH	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										2t. DATE OF DEATH	
13e. STREET ADDRESS Rt. 6 Port Tobacco, Md.										2u. DATE OF DEATH	
14. FATHER'S NAME FIRST MIDDLE LAST Albert Heard										2v. DATE OF DEATH	
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosaline Carroll										2w. DATE OF DEATH	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No										2x. DATE OF DEATH	
16b. SOCIAL SECURITY NO. N/A										2y. DATE OF DEATH	
17. INFORMANT ADDRESS Albert Heard - Welcome, Maryland										2z. DATE OF DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										2aa. DATE OF DEATH	
PART 1 DEATH WAS CAUSED BY:										2ab. DATE OF DEATH	
IMMEDIATE CAUSE (a) Shotgun wounds of head and neck										2ac. DATE OF DEATH	
DUE TO, OR AS A CONSEQUENCE OF										2ad. DATE OF DEATH	
(b) _____										2ae. DATE OF DEATH	
DUE TO, OR AS A CONSEQUENCE OF										2af. DATE OF DEATH	
(c) _____										2ag. DATE OF DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										2ah. DATE OF DEATH	
19a. DATE OF OPERATION										2ai. DATE OF DEATH	
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										2aj. DATE OF DEATH	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										2ak. DATE OF DEATH	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										2al. DATE OF DEATH	
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 10 17 81										2am. DATE OF DEATH	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject shot										2an. DATE OF DEATH	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>										2ao. DATE OF DEATH	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road										2ap. DATE OF DEATH	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE Rt. 6 hr. Poorhouse Rd., Port Tobacco, Charles, MD.										2aq. DATE OF DEATH	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .										2ar. DATE OF DEATH	
ACTUAL SIGNATURE Thomas D. Smith, M.D.										2as. DATE OF DEATH	
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.										2at. DATE OF DEATH	
ADDRESS 111 Penn St. Balto., Md.										2au. DATE OF DEATH	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial										2av. DATE OF DEATH	
23b. DATE 10-22-81										2aw. DATE OF DEATH	
23c. NAME OF CEMETERY OR CREMATORY Our Lord Jesus Christ Ironsides, Charles, Md.										2ax. DATE OF DEATH	
23d. LOCATION CITY OR TOWN COUNTY STATE										2ay. DATE OF DEATH	
24. FUNERAL DIRECTOR NAME Thornton's Funeral Home Pomonkey, Md.										2az. DATE OF DEATH	
ADDRESS										2ba. DATE OF DEATH	
25a. DATE REC'D. BY REGISTRAR OCT 23 1981										2bb. DATE OF DEATH	
25b. REGISTRAR'S SIGNATURE										2bc. DATE OF DEATH	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80  
(VRA 15, 4)STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.



1 - FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 1 2 6 6 6 3	
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HENRY N/M/N COMPTON			2a DATE OF DEATH MONTH DAY YEAR 10/28/81		2b HOUR 10:28AM
3 SEX Male	4 RACE Cauc.	5 DATE OF BIRTH MONTH DAY YEAR 02 17 98		6 AGE (IN YEARS LAST BIRTHDAY) 83 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7 BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ches Co. Md.	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH CHARLES MD.	
10 CITY OR TOWN OF DEATH LA PLATA	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PHYSICIANS MEMORIAL HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer	12b KIND OF BUSINESS OR INDUSTRY Farming	
13a STATE Maryland	13b COUNTY Charles	13c CITY OR TOWN La Plata	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS Rt 1- Box 136E	
14 FATHER'S NAME FIRST MIDDLE LAST Henry Compton, Sr		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louise Wood			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES NO		16b SOCIAL SECURITY NO. 215-38-3212		17 INFORMANT ADDRESS Donald Few same as #13	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 4860 DUE TO, OR AS A CONSEQUENCE OF (b) Bilateral pneumonia. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1m 30 days					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOI WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 23 Dec 1960 to 28 Oct 1981, that (I) (we) last saw the deceased alive on 28 Oct 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE Arthur O. Wooddy, MD		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 28 Oct 81	
22d PHYSICIAN'S NAME (TYPE OR PRINT) ARTHUR O. WOODDY, M.D.		22e ADDRESS JARWOOD CLINIC LA PLATA, MARYLAND 20646			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 10-31-81	23c NAME OF CEMETERY OR CREMATORY Mt. Rest Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE La Plata Charles Maryland	
24 FUNERAL DIRECTOR NAME Arehart Funeral Home		ADDRESS La Plata, Md.		25a DATE REC'D BY REGISTRAR NOV 02 1981	
				25b REGISTRAR'S SIGNATURE Charles J. Nathan	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>LOUIS A/N/A LEWIS JERMIA GILL</b>												2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>10 12 19 81</b>	
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 3, 1938</b>		6. AGE (IN YEARS) LAST BIRTHDAY) <b>42 YRS.</b>		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2b. DATE PRONOUNCED DEAD <b>10 12 19 81</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Penn</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Charles Co.</b>			
10. CITY OR TOWN OF DEATH <b>La Plata</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Physicians Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Mechanic</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Auto</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Charles</b>		13c. CITY OR TOWN <b>Waldorf</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Berry Road Rt. #2 Box 200</b>					
14. FATHER'S NAME FIRST <b>Thomas</b> MIDDLE <b>Winefield</b> LAST <b>Gill</b>						15. MOTHER'S MAIDEN NAME FIRST <b>Gertrude</b> MIDDLE <b>Madalin</b> LAST <b>Elles</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. <b>Korean</b>		16c. SOCIAL SECURITY NO. <b>181-30-3808</b>		17. INFORMANT ADDRESS <b>Margaret T. Gill same as 13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>8120 IMMEDIATE CAUSE (a) Multiple injuries</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR MONTH DAY YEAR <b>7:49 P.M. 10-12-19 81</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Driver in auto/auto collision.</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>road</b>				21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Rt. 225 w. of Rosehill Rd. Charles Md.</b>					
22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE 						TITLE (SPECIFY) <b>M.D. Assistant</b>			MEDICAL EXAMINER				
EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>						ADDRESS <b>111 Penn St.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>10-15-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Md. Vet. Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cheltenham, P.G., Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Huntt Funeral Home, Waldorf, Maryland</b>						25a. DATE REC'D. BY REGISTRAR <b>OCT 19 1981</b>		25b. REGISTRAR'S SIGNATURE 					



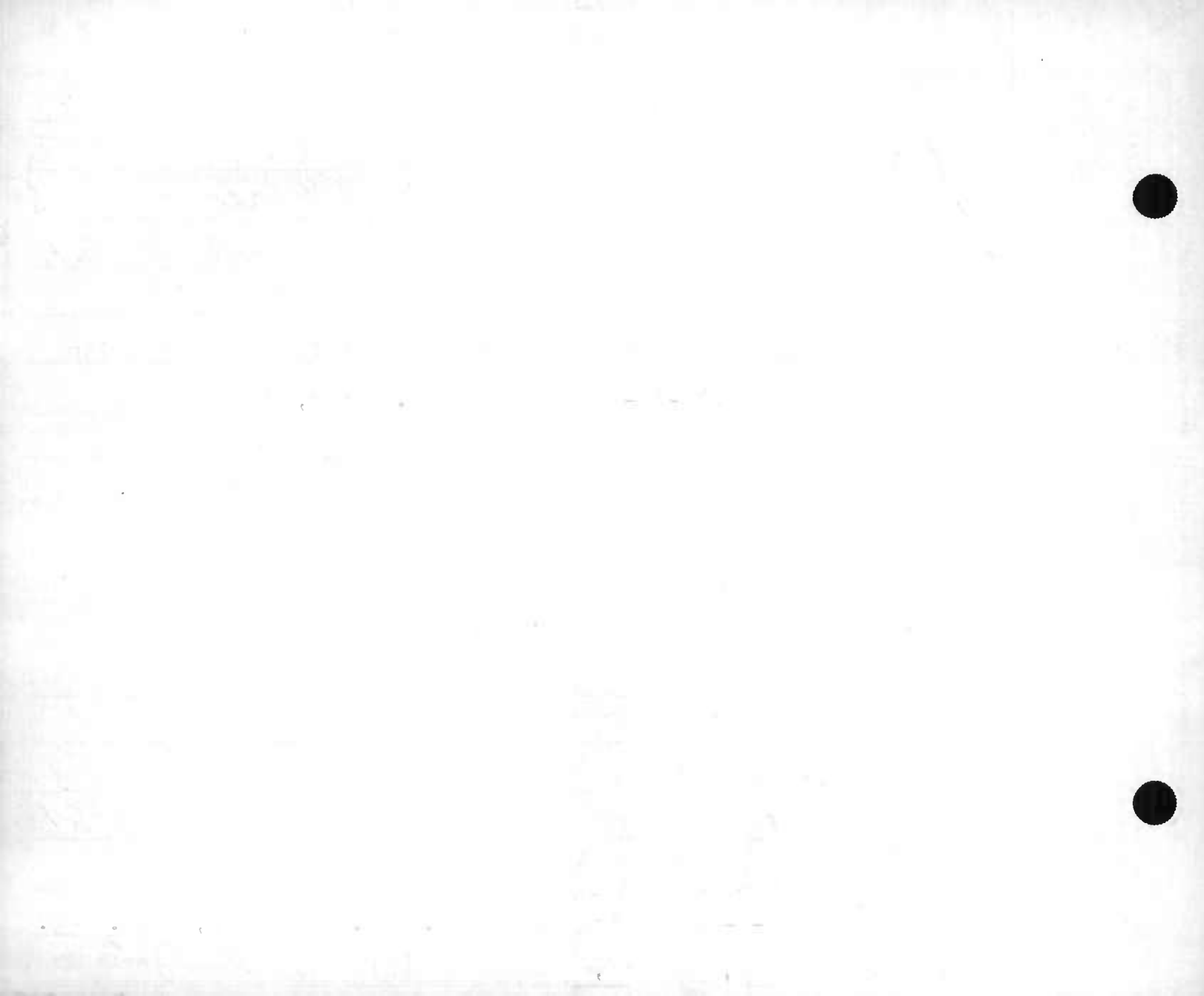
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified for ane.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 1 2 6 6 6 5			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>SYLVIA Louise GOLDEN</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>October 3 1981</b>		2b. HOUR <b>4:25</b> M	
3. SEX <b>Female</b>		4. RACE <b>Can.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11-24-19</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>61</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Charles</b> MD.	
10. CITY OR TOWN OF DEATH <b>LAPLATA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PHYSICIANS MEMORIAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Postal worker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov.</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b> 13b. COUNTY <b>Chas.</b> 13c. CITY OR TOWN <b>Nandyway</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Rt 1 Box 67B.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Alexander Renner Golden</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Addie Lucille Halslip</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>214-12-7486</b>		17. INFORMANT ADDRESS <b>Laurence D. Davis, Same as # 13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Respiratory Collapse.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>1749</b> (b) <b>Melanotic Carcinoma to chest</b> (c) <b>Carcinoma of right breast</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b> <b>3 yrs</b> <b>6 yrs</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Removal of Carcinoma of breast, radical, plus Cobalt + X-ray</b>							
19a. DATE OF OPERATION <b>1975</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Carcinoma of breast</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b> P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>July 19 50</b> to <b>3 Oct 19 81</b> , that (I) (we) last saw the deceased alive on <b>2 Oct 81</b> 19 <b>81</b> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Arthur O. Wooddy MD</b> DEGREE <b>MD</b>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3 Oct 81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ARTHUR O. WOODDY MD</b>				22e. ADDRESS <b>LAPLATA, MD 20646</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10-6-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Chicamuxen Meth. Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Chicamuxen, Chas. Md.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Huntt Funeral Home, Waldorf, Maryland</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 7 1981</b>		25b. REGISTRAR'S SIGNATURE <b>James J. [Signature]</b>	

BP



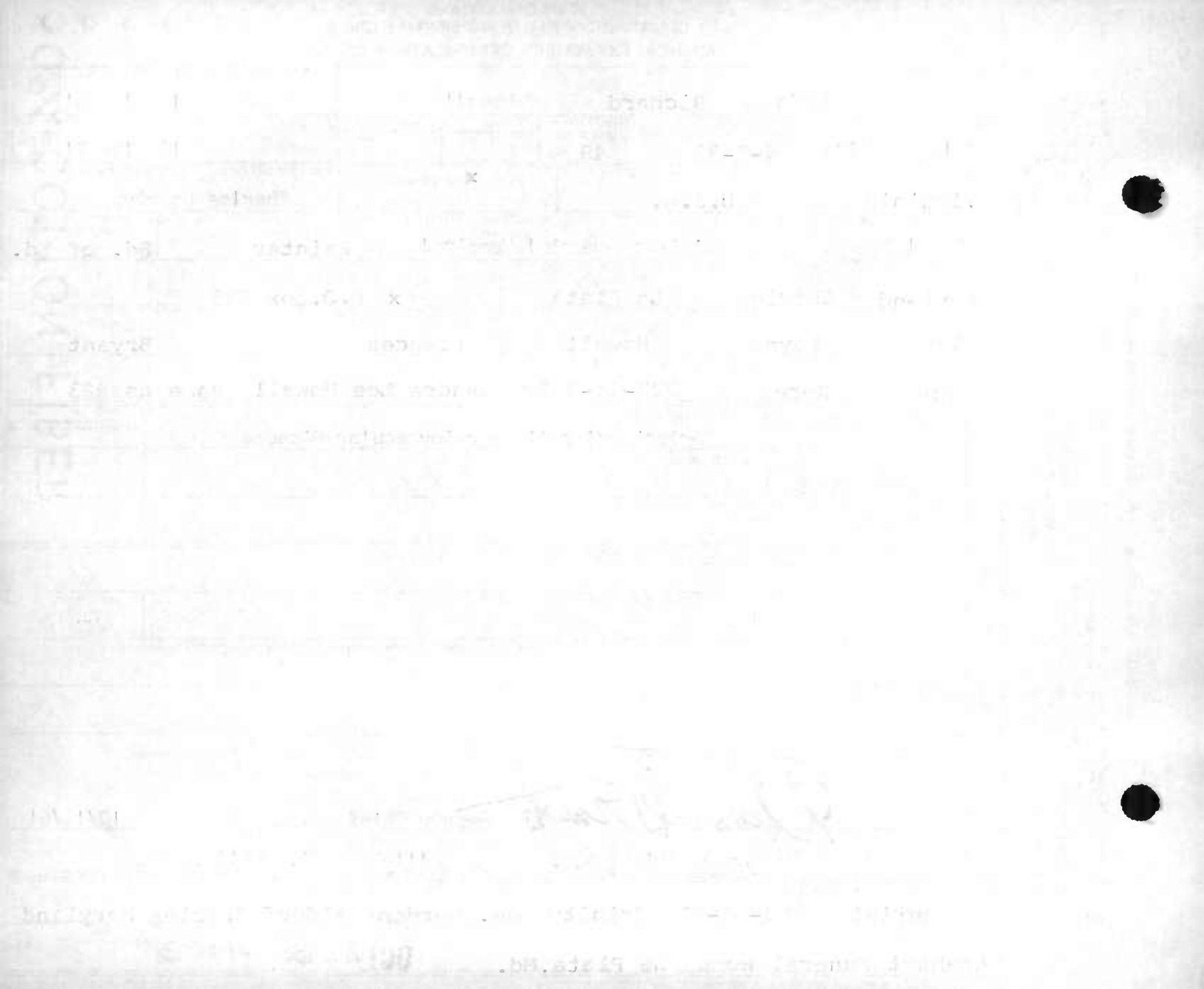


TO EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR) 15 ME (5/1)  
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 26666	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Edwin Richard Howell						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR 10 18 81		2b. HOUR M 8:05 a M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4-2-33		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 48		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles County, MD.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 10 18 81		2d. HOUR a M	
10. CITY OR TOWN OF DEATH La Plata		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Painter		12b. KIND OF BUSINESS OR INDUSTRY Bd. of Ed.			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. CITY OR TOWN Charles		13c. CITY OR TOWN La Plata		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS P.O. Box 315			
14. FATHER'S NAME FIRST MIDDLE LAST Floyd Payne Howell				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Bryant							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. Korea 227-44-9499		17. INFORMANT ADDRESS Sandra Lee Howell same as #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Thomas D. Smith</i>				TITLE (SPECIFY) M.D. Deputy Chief				MEDICAL EXAMINER DATE SIGNED 10/18/81			
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.				ADDRESS 111 Penn St. Balto., MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-21-81		23c. NAME OF CEMETERY OR CREMATORY Trinity Mem. Garden		23d. LOCATION CITY OR TOWN Waldorf		COUNTY Charles		STATE Maryland	
24. FUNERAL DIRECTOR NAME Arehart Funeral Home La Plata, Md.						25a. DATE REC'D. BY REGISTRAR OCT 22 1981		25b. REGISTRAR'S SIGNATURE <i>James C. Smith</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

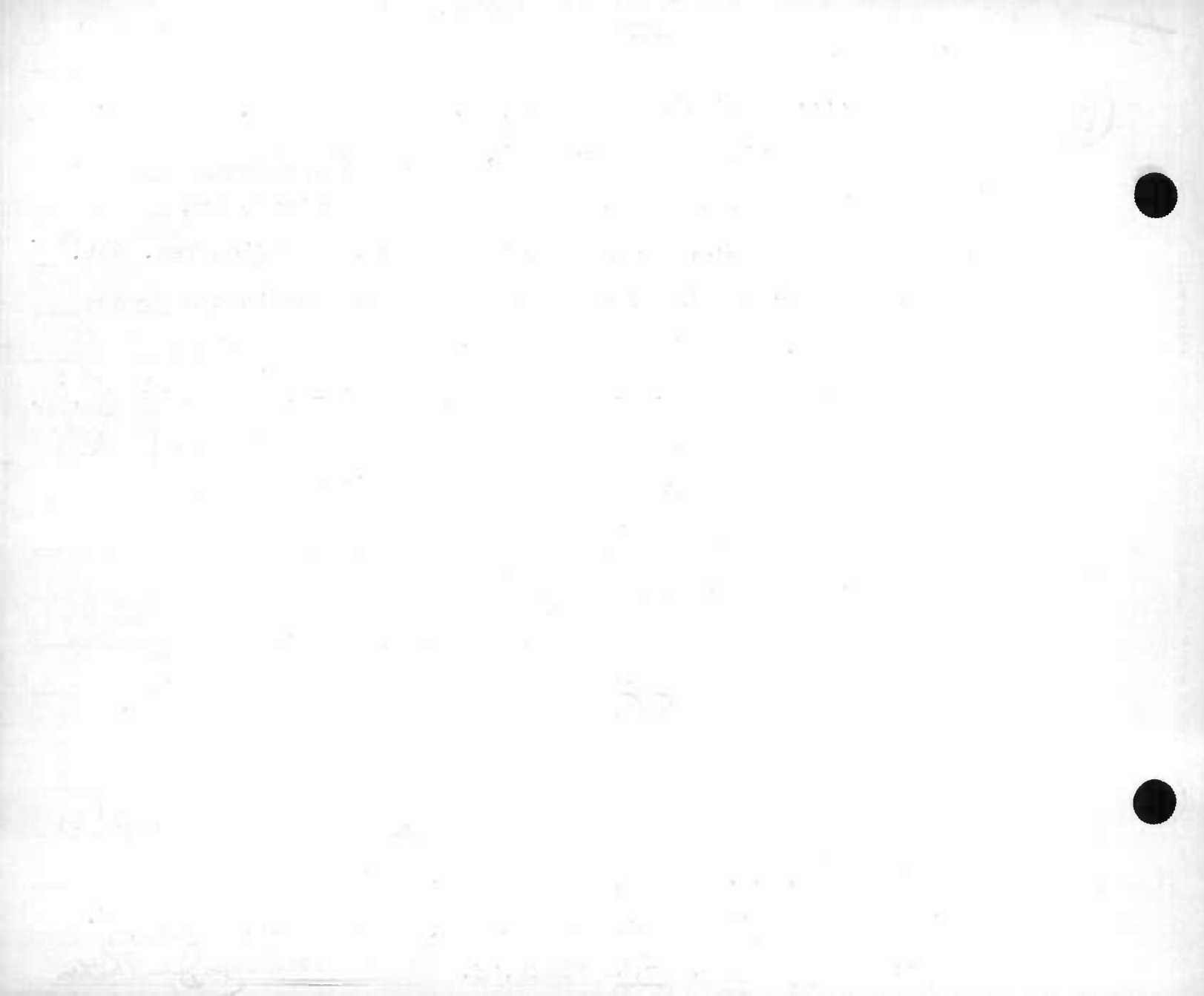
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR										
1. DECEASED NAME (TYPE OR PRINT) Omer / Omar / Benjamin Kendig, Jr.					2a. DATE OF DEATH MONTH DAY YEAR Oct. 2, 1981			2b. HOUR 3:00 a.m.		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 17, 1917		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles County, MD.				
10. CITY OR TOWN OF DEATH La Plata		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Central Office		12b. KIND OF BUSINESS OR INDUSTRY Tel. Rec. Ret.		
13a. STATE Maryland					13b. COUNTY Charles		13c. CITY OR TOWN La Plata			
14. FATHER'S NAME FIRST MIDDLE LAST Omer B. Kendig					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Albright					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 11		17. INFORMANT ADDRESS 600 Washington Avenue, La Plata, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): <u>Acute Inferior Wall Myocardial Infarction</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b): <u>Multifactorial Arrhythmia 20 to 1.</u> DUE TO, OR AS A CONSEQUENCE OF (c): <u>Severe Hypertension</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <u>Renal Insufficiency</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>9/21</u> , 19 <u>81</u> , to <u>10/2</u> , 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>10/1</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death)										
22b. SIGNATURE <u>George H. Wathen</u> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED 10/2/81.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial					23b. DATE 10/5/1981		23c. NAME OF CEMETERY OR CREMATORY Mount Rest Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE La Plata, Charles Md.	
24. FUNERAL DIRECTOR NAME Arehart Funeral Home, Inc., La Plata, Md.					25. DATE REC'D. BY REGISTRAR (25b. REGISTRAR'S SIGNATURE) OCT 5 1981 <u>George H. Wathen</u>					

BP \_\_\_\_\_

DHMH-16 20M  
(VRA 15, 4) 7/78



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 2 6 6 6 8

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>SALOME Hildagarde KREFT</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10 2 81</b>		2b. HOUR <b>9:00A M</b>
3 SEX <b>Female</b>	4. RACE <b>Cau.</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 5, 1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Michigan</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>CHARLES</b> MD.	
10 CITY OR TOWN OF DEATH <b>LA PLATA</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PHYSICIANS MEMORIAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Dept. Store</b>
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Charles</b>	13c. CITY OR TOWN <b>Indian Head</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>3 Irving Place</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Kreft</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Katherine Hauck</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>579-10-4021</b>		17. INFORMANT ADDRESS <b>Clara K. Adams same as 13</b>	

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>9-30</b> , 19 <b>81</b> , to <b>10-2</b> , 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>10-2</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>CHINMOY BANERJEE</b>		DEGREE		22c. DATE SIGNED <b>Oct 2, 1981</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CHINMOY BANERJEE, M.D.</b>		22e. ADDRESS <b>CHARLES PROFESSIONAL BUILDING WALDORF, MD.</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>10-5-81</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cem.</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Bryantown, Charles, Md.</b>
24. FUNERAL DIRECTOR NAME <b>Hunt Funeral Home, Waldorf, Md.</b>		25a. DATE RECEIVED BY REGISTRAR <b>OCT 7 1981</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carboncopiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified promptly.

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

REPORT OF THE  
COMMISSIONER OF PLANT INDUSTRY  
FOR THE YEAR 1901  
CONTAINING  
A SUMMARY OF THE WORK OF THE BUREAU  
AND A LIST OF THE PLANTS INTRODUCED  
DURING THE YEAR  
BY THE BUREAU OF PLANT INDUSTRY  
AND BY OTHER AGENCIES  
UNDER THE ACT OF MARCH 3, 1878  
AND THE ACT OF MARCH 3, 1901  
AND A LIST OF THE PLANTS  
INTRODUCED BY THE BUREAU  
DURING THE YEAR  
BY THE BUREAU OF PLANT INDUSTRY  
AND BY OTHER AGENCIES  
UNDER THE ACT OF MARCH 3, 1878  
AND THE ACT OF MARCH 3, 1901

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COMMISSIONER OF PLANT INDUSTRY  
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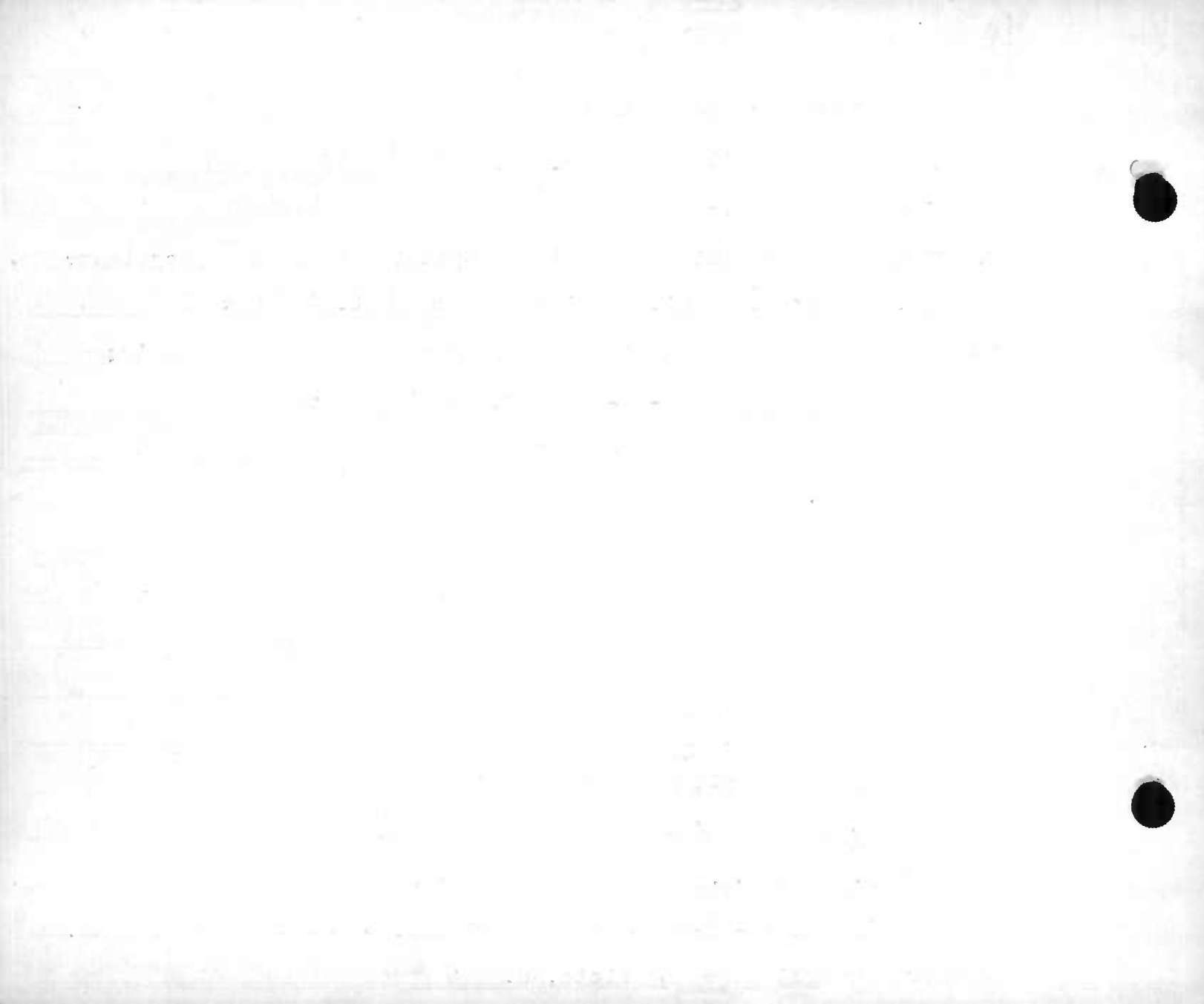
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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 1 2 6 6 6 9			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Robert Milton Lewis				2a. DATE OF DEATH 10-7-81		2b. HOUR 835P M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH Mar. 26, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles MD.	
10. CITY OR TOWN OF DEATH La Plata		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman		12b. KIND OF BUSINESS OR INDUSTRY Appliance Co.	
13a. STATE Md.				13b. CITY OR TOWN Charles		13c. STREET ADDRESS Rt.#2 Box 18	
14. FATHER'S NAME FIRST MIDDLE LAST Max Lewis				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Sherman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 235-03-9902		17. INFORMANT ADDRESS Ruth Lewis same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Obstruction</u> 5198 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Chronic Lung Disease, ASHD, Renal Failure, Diabetes Mellitus</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from _____, 19____, to <u>10-7-</u> 19 <u>81</u> , that (1) (we) last saw the deceased alive on <u>19-81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Henry L. Burke M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10-7-81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Henry L. Burke, M.D.				22e. ADDRESS La Plata, MD 20646			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-12-81		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE La Plata Charles Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Arehart Funeral Home La Plata, Md.				25a. DATE REC'D. BY REGISTRAR OCT 14 1981		25b. REGISTRAR'S SIGNATURE <u>James J. Hays</u>	

BP \_\_\_\_\_

DHMH-16 20M  
(VRA 15, 4) 7/78





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 2 6 6 7 0

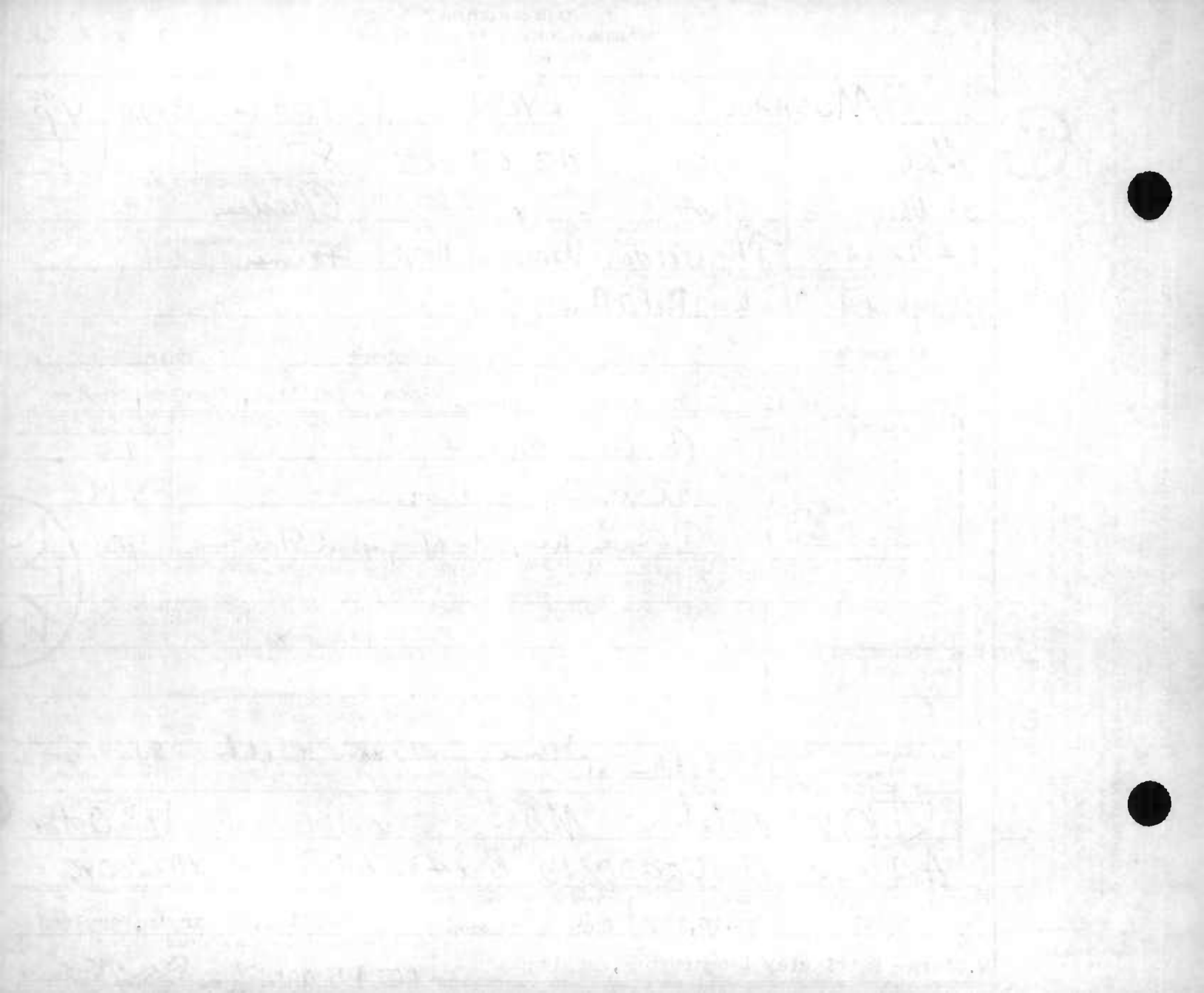
REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MUSHAW LYON</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>October 13, 1981</b>		2b. HOUR 4 <sup>00</sup> PM	
1. SEX <b>Male</b>		4. RACE <b>Can.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>02 03 1894</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS	
7a. BIRTHPLACE (STATE OR COUNTY) <b>St. Mary's Co.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Charles</b> MD.	
10. CITY OR TOWN OF DEATH <b>LAPLATA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Physicians Memorial Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Farmer</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Charles</b>		13c. CITY OR TOWN <b>BelAlton</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS		14. FATHER'S NAME FIRST MIDDLE LAST <b>Alexander Lyon</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Roberta Ching</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>WW 11 217 36 7089</b>		17. INFORMANT ADDRESS <b>Eugene Lyon BelAlton, Charles, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>6000</b> IMMEDIATE CAUSE (a) <b>Cardiac arrest.</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Urinary retention.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Prostate hypertrophy and Stricture.</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b> <b>48 hr.</b> <b>Years</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>June</b> , 19 <b>1948</b> to <b>Oct</b> , 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>13 Oct</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ARTHUR O. WOODDY, MD.</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>13 Oct 81</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Oct. 16, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Christ Episcopal</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Chaptico, St Mary's, Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>W. Clarke Mattingley Leonardtown, Maryland</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 16 1981</b>			
				25b. REGISTRAR'S SIGNATURE <b>Phance Van Natter</b>			

MEDICAL CERTIFICATION

29

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examination required.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 2 6 6 7 1			
1- FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Louise Stone Matthews</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>October 24, 1981</b>		2b. HOUR <b>11:20A</b>	
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>January 28, 1897</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Charles</b> MD.	
10. CITY OR TOWN OF DEATH <b>La Plata</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Physicians Memorial Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>				13b. COUNTY <b>Charles</b>		13c. CITY OR TOWN <b>La Plata</b>	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS <b>Oak Avenue</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Matthews</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Jennie Stone</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>218-34-5793</b>		17. INFORMANT ADDRESS <b>John W. Matthews same as #13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4149</b> IMMEDIATE CAUSE (a) <b>Cardiac Arrest - Cardiogenic Shock</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Artery disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION ____		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ____		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ____ P.M. ____ 19 ____		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) ____			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) ____		21f. LOCATION STREET CITY OR TOWN COUNTY STATE ____			
22a. I certify that (I) (the hospital) attended the deceased from <b>10/23/81</b> , 19____, to <b>10/24/81</b> , 19____, that (I) (we) last saw the deceased alive on <b>10/24/81</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (I) did not view the body after death, so state.)							
22b. SIGNATURE <b>Sanjeeb K. Mishra</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>10/24/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Sanjeeb K. Mishra, M.D.</b>				22e. ADDRESS <b>La Plata, Md. 20646</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10-27-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Rest Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>La Plata Charles Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Arehart Funeral Home, Inc. La Plata, Md.</b>				25a. DATE REC'D BY REGISTRAR <b>OCT 30 1981</b>			
				25b. REGISTRAR'S SIGNATURE <b>Frances Jan Nathan</b>			

The State Department has been advised by the FBI that the above information was obtained from a confidential source who has provided reliable information in the past.

[illegible]

100-27-273 John L. Patterson

• - 2 - East Country 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 8

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHM-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 1 2 6 6 7 2			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Michael A Moses				2a. DATE OF DEATH MONTH DAY YEAR October 3, 1981		2b. HOUR 9:48AM	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 04-30-30-1928		6. AGE (IN YEARS LAST BIRTHDAY) 53-53 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles MD.	
10. CITY OR TOWN OF DEATH La Plata		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) School Teacher		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland				13b. COUNTY St. Mary's		13c. CITY OR TOWN Bushwood	
14. FATHER'S NAME FIRST MIDDLE LAST Isaac Z. Moses				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia M. Mamary			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 165-20-9214		17. INFORMANT ADDRESS Julia Moses, Wilkes-Barre, Pennsylvania			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u> 4151 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <u>PULMONARY EMBOLISM</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>HYPERURICEMIA, HYPERTENSION, OBESITY</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>SEP 23</u> , 19 <u>81</u> , to <u>OCT 3</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>OCT 2</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Guillermo E. Sanchez, M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10-3-81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Guillermo Sanchez, M.D.				22e. ADDRESS La Plata, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-7-81		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Brinsfield Funeral Home, Leonardtown, Maryland				25a. DATE REC'D. BY REGISTRAR OCT 20 1981		25b. REGISTRAR'S SIGNATURE <u>James J. [Signature]</u>	

MEDICAL CERTIFICATION

THE LAMDA COMPANY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) <b>Jane Proctor</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>October 31, 1981</b>				2b. HOUR <b>8:15A</b>	
3. SEX <b>female</b>		4. RACE <b>black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>January 6, 1913</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Charles</b> MD.			
10. CITY OR TOWN OF DEATH <b>La Plata</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Physicians Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Private</b>	
13a. STATE <b>Maryland</b>				13b. CITY OR TOWN <b>Charles</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS <b>N/A</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Augustus Key</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth Proctor</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>216-22-2149</b>		17. INFORMANT ADDRESS <b>Lillian M. Proctor Welcome, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>4639</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic Renal failure</b> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>Myocardial infarction &amp; infection</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>10-30</b> , 19 <b>81</b> , to <b>10-31</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>10-30</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Ignacio Garcia, M.D.</b>				DEGREE <b>M.D.</b>				22c. DATE SIGNED <b>10-31-81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Ignacio Garcia, M.D.</b>				22e. ADDRESS <b>La Plata, Maryland 20646</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov. 4, 81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Zion Baptist</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hilltop Charles, Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Thornton Funeral Home Pomonkey, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 5 1981</b>		25b. REGISTRAR'S SIGNATURE <i>Charles J. Smith</i>			

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE		8 1 2 6 6 7 4						
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	A.
Charles Alfred Richardson					October 14, 1981				9:03	M
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male	White	May 28, 1912		69		MONTHS		DAYS		HOURS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
Virginia	U.S.A.			Charles						MD.
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
La Plata	Physicians Memorial Hospital		Steam Fitter		Ret./Welder					
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS					
Maryland		Cobb Island	Cobb Island	NO	#48 North East Crain Bld.					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME								
Walter Richardson		Molly R. Sparks								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				
NO		226-01-0206		Beatrice Richardson		same as #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY		IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
1629		METASTATIC LARGE CELL CARCINOMA BLUNG		4 mos						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF						
		(c)		DUE TO, OR AS A CONSEQUENCE OF						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (the hospital) attended the deceased from <u>JULY 6, 1981</u> to <u>OCTOBER 8, 1981</u> , that (I) (we) last saw the deceased alive on <u>OCTOBER 8, 1981</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.										
22b. SIGNATURE		DEGREE		22c. DATE SIGNED						
James A. Brown MD				10/15/81						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS								
JAMES A. BROWN MD		6525 BELMONT RD HYATTSVILLE, MD 20782								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial		10-17-81		Graham Cemetery		Orange Orange Virginia				
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Arehart Funeral Home, Inc.-La Plata, Md.				OCT 19 1981		James Santherton				

BP

10-15-51

James A. Brown (Wid)  
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Wanda A. Brown (Wid)

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (5))  
15M2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 1 26675	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Henry Samuel Nelson Thompson										2b. DATE KNOWN OF DEATH MONTH DAY YEAR 10 25 19 81	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 28, 1908		6. AGE (IN YEARS) LAST BIRTHDAY YRS. 73		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 10 25 19 81	
9. BALTIMORE CITY OR COUNTY OF DEATH Charles County, MD.				10. CITY OR TOWN OF DEATH La Plata				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 2, Box 2075			
12a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. CITY OR TOWN Charles		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS Rural Route #2, Box 2075			
14. FATHER'S NAME FIRST MIDDLE LAST Henry Clarence Thompson						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kate Emma Lyon					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-22-1803A		17. INFORMANT Rural Route #2, Box 2075, Martha Mae Thompson-Wife, La Plata, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound to head (rifle)</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 10.											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10+ xx 10 25 19 81		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) self inflicted					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Rt. 2, Box 2075 LaPlata Charles Md.					
22a. I certify that I have charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <i>Thomas D. Smith</i>				TITLE (SPECIFY) M.D. Deputy Chief				MEDICAL EXAMINER DATE SIGNED 10/26/81			
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.				ADDRESS 111 Penn St. Balto., MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 10/28/81		23c. NAME OF CEMETERY OR CREMATORY Trinity Church Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Newport, Charles Co, Md			
24. FUNERAL DIRECTOR NAME ADDRESS Arehart Funeral Home, Inc.-La Plata, Md.						25a. DATE REC'D. BY REGISTRAR NOV 02 1981		25b. REGISTRAR'S SIGNATURE <i>Frances Jan. Matheson</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the local health department. Page 3 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted at once.

1. FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 1 2 6 6 7 6 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)				FIRST MIDDLE LAST				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR P			
James Walter Waters								October 12, 1981				11:20 M			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.					
Male		Caucasian		8-3-1918		63 YRS.									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
Maryland		U.S.A.				Charles MD.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
La Plata		Physicians Memorial Hosp.						Traffic Control		D.C. Gov't.					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS	
Maryland				Charles		Waldorf						3004 Gallery Place Apt. 21			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
Thaddeus Waters				Bertha Adams											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT											
Yes		WW Two		215-14-7456		James C. Waters						918 S Truro Lane Waldorf, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-pulmonary Failure</u> <u>1990</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>2<sup>nd</sup> carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>9-20-81</u> to <u>10-12-81</u> , that (I) (we) last saw the deceased alive on <u>10-12-81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <u>Mohammed Haziq</u> DEGREE											22c. DATE SIGNED <u>10/13/81</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Mohammed Haziq M.D.</u>											22e. ADDRESS <u>La Plata, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial				10-16-81		St. Marys Cemetery				Bryantown Charles Md.					
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Huntt Funeral Home Waldorf, Maryland						OCT 19 1981		<u>James C. Northen</u>							

James Miller 1921-1922

1923-1924

1925-1926

1927-1928

1929-1930

1931-1932

1933-1934

1935-1936

1937-1938

1939-1940

1941-1942

1943-1944

1945-1946

1947-1948

1949-1950

1951-1952

1953-1954

1955-1956

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

**M**

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
1. FOR STATE REGISTRAR		REG. NO.				8 1 2 6 6 7 7							
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			MONTH		DAY		YEAR		2b. HOUR	
FIRST MIDDLE LAST Daisy Hazel Williamson			October		07		1981		5:35		P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS			
Female		Can.		03 24 09		72		MONTHS		DAYS		HOURS MIN.	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		9b. CITIZEN OF WHAT COUNTRY?		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		USA				Charles							
12. CITY OR TOWN OF DEATH		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		14. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE)		15. KIND OF BUSINESS OR INDUSTRY							
LAPLATA		Physicians Memorial Hosp.		Housewife		at Home							
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		17. INSIDE CITY LIMITS?		18. STREET ADDRESS									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt I Box 132					
Maryland		Charles		Nanjemoy									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST		FIRST MIDDLE LAST											
Edward Clarence Bastain		Alice Hazel Finall											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO		17. INFORMANT		5761 Benford Drive							
No		225-10-5802		Ruby Heflin-Sister		Haymarket, Va.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1: DEATH WAS CAUSED BY:										20 min			
IMMEDIATE CAUSE (a) Cardiac arrest													
DUE TO, OR AS A CONSEQUENCE OF										10 yrs			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										Generalized arteriosclerotic Cardiovascular disease			
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										depression			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
		HOUR A.M. MONTH DAY YEAR											
		P.M. 19											
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET									
22a. I certify that (I) (the hospital) attended the deceased from June 19 1980, to 7 Oct 19 81, that (I) (we) last saw the deceased alive on 7 Oct 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED							
Arthur O. Wooddy M.D. P.A.						7 Oct 81							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
ARTHUR O. WOODDY, M.D., P.A.		Box 450 LAPLATA, MD 20646											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE	
Burial		10/10/81		Nanjemoy Baptist Cem.		Nanjemoy, Charles Co., Md.							
24. FUNERAL DIRECTOR		25. DATE REC'D. BY REGISTRAR		25a. REGISTRAR'S SIGNATURE									
Name		ADDRESS											
Arehart Funeral Home, Inc.-La Plata, Md.		OCT 14 1981											

